

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155388		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/20/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK				STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to Complaint IN00099662 completed on November 16, 2011.</p> <p>This visit was in conjunction with the PSR to the Recertification and State Licensure Survey and the Investigation of Complaint IN00100416 completed on December 2, 2011.</p> <p>Complaint IN00099662- Corrected.</p> <p>Survey date: January 20, 2012</p> <p>Facility number : 000231 Provider Number : 155388 AIM Number : 100267900</p> <p>Survey Team: Michelle Hosteter, RN-TC Janet Stanton, RN Rita Mullen, RN Heather Lay, RN</p> <p>Census bed type: SNF: 26 SNF/NF: 77 Total: 103</p> <p>Census payor type: Medicare: 16 Medicaid: 59 Other: 28 Total: 103</p> <p>Sample: 14</p> <p>Manorcare Health Services- Prestwick was found</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/20/2012	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK				STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	Continued From page 1 to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00099662. Quality review completed on January 26, 2012 by Bev Faulkner, RN			{F 000}			